VERMONT

MULTIPLE SCLEROSIS SELF INJECTABLES - Patient Enrollment/Order Form

Complete form in its entirety and fax to number listed below

1 PATIENT INFORMATION

Last Name	First Name	Middle Initial

Date of Birth	Sex	Medicaid ID #
	M ☐ F ☐	

Allergies: ☐ NKA or _____

Street Address	City

State	County	Zip Code

Home Phone	Cell Phone

Parent/Guardian	Day Telephone	Night Telephone

Emergency Contact	Relationship	Telephone

2 PRESCRIBER INFORMATION

Prescriber's Name	NPI Number	DEA Number

Telephone Number	Fax Number	Hospital/Clinic Name

Street Address	City

State	County	Zip Code

Contact Person at Office	Prescriber Specialty

icore PHARMACY SERVICES

MedMetrics HealthPartners

Fax Completed Form to:

Fax Number: 866-364-2673

Phone Number: 800-327-1392

3 Office of Vermont Health Access PRESCRIPTION MULTIPLE SCLEROSIS SELF INJECTABLES

Patient Diagnosis:

Product:

☐ Avonex 30 mcg/0.5 ml Prefilled Syringe (4 per box)

☐ Avonex 30 mcg Kit (Single Dose Vials) (4 per box)

☐ Betaseron 0.3 mg Prefilled Syringe

☐ Copaxone 20 mg Prefilled Syringe (30 per kit)

☐ Rebif Titration Pack X 1 **(Therapy initiation ONLY-No Refills)**
(contains 6 - 8.8 mcg and 6 – 22 mcg Prefilled Syringes)

☐ Rebif 22 mcg/0.5 ml Prefilled Syringes

☐ Rebif 44 mcg/0.5 ml Prefilled Syringes

(Please Note: This form not to be used for Tysabri PA request or ordering)

Quantity:	**Refills:**

Dose / Route/ Frequency Instructions (Sig):

Deliver product to: ☐ Patient's home ☐ MD office ☐ Clinic

☐ Needles/syringes: quantity sufficient for drug supply with refills as above

Prescriber's Signature: _____ **Date:** _____

Last Updated 10/2008